

deeply than in lumbago; and its nature is further explained by the fever and rigors which ordinarily precede it. If this condition persist seven or eight days, it may be predicted that pus has been formed in the areolar tissue surrounding the kidney. At this time, also, inspection and palpation of the lumbar region may detect, if not fluctuation (which is rarely absent), at least sensible tumefaction of the lumbar region with a pasty or cedematous feel, especially behind. But even if these external signs be absent, the sympathetic reaction, with the history of the case (if the perinephritis be not primary, in which case the diagnosis is very difficult), are sufficient to render the diagnosis of phlegmon almost a matter of certainty.

The *prognosis* is grave; for, if the existence of the phlegmon be not diagnosed, and if issue be not given to the accumulated pus, it may spread to the right or left, or be effused into the peritoneum, etc.; and the inflammation may extend to neighbouring organs, as the spleen or lung. Even in the most favourable cases, where the abscess opens spontaneously outwards, troublesome fistulæ are formed; the pus becomes thin, decomposed, and acts as a formidable poison.

When suppuration has once taken place, the only *treatment* is to allow it exit by a large opening. M. Jobert is opposed to the plan of making a small incision with a narrow bladed bistoury, as the muscles of the back must be cut through, and, if an artery be divided, it is impossible to secure it. He therefore advises a long incision. The tissues must be divided layer by layer, and as each is reached, the finger must be carried to the bottom of the wound. If an artery be felt, it must be tied and divided; if a vein, it is divided between two ligatures. The covering of the purulent collection being at last reached, a small opening is made, on which the pus escapes; and the aperture may be enlarged by scissors or by a probe-pointed bistoury, in order to allow the free escape of the pus, or of calculi if they be present.—*Brit. Med. Journ.*, Oct. 10, from *Journ. de Méd. et de Chirurg. Prat.*, Aug. 1863.

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34. *Cancerous Infiltration of the Entire Penis.*—MR. HOLMES COOTE communicated to the Royal Med. and Chirurg. Soc. (Nov. 10, 1863) the following interesting and unusual case:—

A man was admitted into St. Bartholomew's Hospital, under the care of Mr. Coote, with cancerous infiltration of the entire penis. It was found that he could not inhale chloroform without showing alarming symptoms of collapse. In the course of a month he died. On examination afterwards it was found that the whole penis was occupied by soft cancerous deposit; that there was a cancerous ulcer of the bladder; cancerous deposits in the lungs and bronchial glands, and several of the bones. The head was not examined. The heart was in a state of extreme fatty degeneration.

In reply to the President, Mr. Coote said that there was no enlargement of the inguinal glands, but there was of the glands in the pelvis. The phimosis was not congenital.

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35. *Inequality in the Length of the Limbs.*—Inequality in the development of the limbs, arising from certain occupations, has hitherto been most generally noticed as it affects the upper compared with the lower limbs, as in bakers and dancers; but it also occurs between similar limbs, especially the arms, in cases where one of these limbs is actively employed, while the other remains in a more or less complete state of inaction. This inequality, Dr. DUPARCQUE observes, affects the length as well as the volume of the arms, and arises from two sources, viz: the predominant development of the exercised limb; and a kind of arrest of development in that which is condemned to inactivity. In some cases, as in jewellers, cutlers, and smiths, the right arm is lengthened, while the size of the left arm is increased in painters on porcelain. This abnormal development can only occur in subjects who have followed their occupations from an early age—before puberty or at its commencement, when the body is not yet fully developed. This inequality between similar and parallel limbs is regarded by Dr. Duparcque as of some surgical importance. The neglect or ignorance of its occurrence may produce mischievous results in diagnosis, in prognosis, and in operative procedures in those cases of injury, such as dislo-

cation in fracture, in which an alteration in length forms an important feature. As a general rule, Dr. Duparcque says, in all cases of injury of the upper limbs from direct or indirect violence capable of producing fracture or dislocation, the occupation of the patient, and its influence on the development of the limbs, should be inquired into.—*Brit. Med. Journ.*, Ap. 25, 1863, from *Gaz. des Hôp.*, 7 March. 1863.

## OPHTHALMOLOGY.

36. *Recent Modifications in the Methods of Extracting Cataract.*—It appears from statistics of 3000 cases, under careful operators, that about one eye in twelve is lost by the ordinary method of extraction. This has led some of our German brethren to propose certain new methods of performing this operation by which they hoped to obtain better success. Foremost among these is Dr. SCHUFT, of Berlin, who has since, by royal letters patent, changed his name to WALDAU. This method, as described by Dr. Workman,\* from the author's pamphlet, published at Berlin in 1860, is as follows:—

After directing that the lids be separated by a spring speculum, and the globe fixed by a pair of forceps, the surgeon is to make an incision with one of Jaeger's iridectomy knives, within the edge of the cornea for about a fifth of its circumference. He is then to draw out a piece of the iris with a pair of forceps, and cut off about a fifth of it. The whole breadth of the iris is not to be removed, but a belt at its ciliary margin is to be left, so as to afford support to the vitreous, and prevent prolapse of that body. The edge of the lens at this part comes slightly forwards, from having lost some of its support. The capsule is now to be torn through. Dr. Waldau thus describes the way in which the lens is removed: "The surgeon introduces the scoop into the wound, at first pushing on very slantingly towards the centre of the eyeball till it has passed beyond the equator of the advancing lens. He then slopes the handle backwards, at the same time pushing the scoop onwards, as if he meant to shell the lens out of its bed. When the centre of the scoop has reached the posterior pole of the lens, with a lever movement all that is embraced within its broad surface is cautiously lifted out into the anterior chamber. The greater part of the lens is thus removed in one spoonful." Any remaining fragments are taken out by the re-introduction of the scoop. Lastly, the globe is to be lightly rubbed with the lids, so as to wash any fragment that may be concealed behind the iris into the pupillary area. Dr. Waldau uses a scoop with a flat bottom and steep edge, and describes it as having the following advantages:—

1st. That its broad surface enables the operator to support the cataract so as to lever it entire, or in greater part into the anterior chamber.

2d. It has a sharp edge, forming a large curve, by which the scoop can be stuck into the back of a hard lens so as thoroughly to fix it.

3d. The anterior lip being prominent, assists in drawing out a cataract, by pushing it, as it were, from behind.

4th. The stalk is smaller than the breadth of the spoon, so that it does not make the wound gape during the manipulations.

"With the aid of the scoop," he says, "we are able through a linear wound, to remove completely, and without excessive damage and peril to the eye, every lens equally well, whether it be transparent or partially or wholly opaque, and whatever its size or consistence." The ability to fix the eye all through the operation he considers as a great advantage. The following cases Dr. Waldau mentions as suitable for the operation:—

1st. All cataracts in persons above twenty-five or thirty years of age, which have a hard or more or less considerable nucleus.

2d. Not perfectly ripe cataracts in both young and old persons.

3d. Cases of cataract with closed pupil.

4th. Cases with foreign bodies lying in lens.

\* *Med. Times and Gaz.*, Oct. 3, 1863, p. 357.